



COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 347-1604 FAX (562) 941-5835
<http://ems.dhs.lacounty.gov/>

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Commissioners

Mr. Robert Ower

LA County Ambulance Association
Chief Robert E. Barnes
Los Angeles County Police Chiefs Assn.

Mr. Frank Binch
Public Member (4th District)

Erick H. Cheung, M.D., Vice Chair
Southern CA Psychiatric Society

Robert Flashman, M.D.
LA County Medical Association

Mr. John Hisserich
Public Member (3rd District)

Clayton Kazan, M.D., Chair
*California Chapter-American College of
Emergency Physicians (CAL-ACEP)*

Mr. James Lott, Psy.D.
Public Member (2nd District)

FF/Paramedic Paul Rodriguez
CA State Firefighters' Association

Margaret Peterson, Ph.D.
Hospital Association of Southern CA

Lt. Brian Scott Bixler
Peace Officers Association of LA County

Nurses Sanossian, MD, FAHA
*American Heart Association
Western States Affiliate*

Carole A. Snyder, RN
Emergency Nurses Association

Chief David White
LA Area Fire Chiefs' Association

Mr. Colin Tudor
League of CA Cities/LA County Division

Mr. Gary Washburn
Public Member (5th District)

VACANT

Public Member (1st District)
*LA Surgical Society
Southern California Public Health Assn.*

Executive Director

Cathy Chidester, Director, EMS Agency
(562) 347-1604
cchidester@dhs.lacounty.gov

Commission Liaison

Marilyn Rideaux
(323) 890-7392
mrideaux@dhs.lacounty.gov

DATE: July 20, 2016
TIME: 1:00 – 3:00 PM
LOCATION: Los Angeles County EMS Agency
10100 Pioneer Blvd., EMSC Hearing Room – 1st Floor
Santa Fe Springs, CA 90670

The Commission meetings are open to the public. You may address the Commission on any agenda item before or during consideration of that item, and on other items of interest which are not on the agenda, but which are within the subject matter jurisdiction of the Commission. Public comment is limited to three (3) minutes and may be extended by Commission Chair as time permits.

NOTE: Please **SIGN IN** if you would like to address the Commission.

AGENDA

CALL TO ORDER – Clayton Kazan, M.D., Chairman

INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS

CONSENT CALENDAR (Commissioners/Public may request that an item be held for discussion.)

1 MINUTES

- May 18, 2016

2 CORRESPONDENCE

- 2.1 (6-30-2016) Larry Whithorn, Fire Chief, West Covina Fire Department: Newly Appointed Medical Director – Sean Henderson, M.D.
- 2.2 (6-28-2016) Distribution: Designation of Primary Stroke Centers
- 2.3 (6-27-2016) Aaron Aumann, NRP, EMS Department Supervisor, University of Antelope Valley: Paramedic Training Program Approval
- 2.4 (6-23-2016) ED Medical Directors and ED Nurse Managers, Each 9-1-1 Receiving Hospital: End-of-Life Option Act (Aid-In-Dying Drug)
- 2.5 (6-15-2016) Howard Backer, M.D., MPH, FACEP, Director, State Emergency Medical Services Authority: Extension of the Current Exclusive Operating Area Agreements for Emergency 9-1-1 Ambulance Transportation
- 2.6 (6-7-2016) Distribution: Suspended Emergency Department Approved for Pediatrics Status – Pacifica Hospital of the Valley
- 2.7 (6-1-2016) Eligible Physicians, Physicians Services for Indigents Program: Physician Services for Indigents Program – Trauma Services
- 2.8 (5-17-2016) Distribution: Comprehensive Stroke Center Implementation
- 2.9 (4-12-2016) The Honorable Board of Supervisors, County of Los Angeles: Approval of Amendments to Emergency Ambulance Transportation Services Agreements

3. COMMITTEE REPORTS

- 3.1 Base Hospital Advisory Committee
- 3.2 Data Advisory Committee
- 3.3 Education Advisory Committee
- 3.4 Provider Agency Advisory Committee

4. POLICIES – FOR YOUR INFORMATION

- 4.1 Reference No. 814: Determination/Pronouncement of Death in the Field
- 4.2 Reference No. 815: Honoring Prehospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-In-Dying-Drug)
- 4.3 Reference No. 815.3: Sample – Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner
- 4.4 Reference No. 815.4: End of Life Option Field Quick Reference Guide
- 4.5 Reference No. 1200: Treatment Protocols
- 4.6 Reference No. 1319: Medical Control Guideline: Medication Orders and Administration
- 4.7 Reference No. 1329: Medical Control Guideline: Perfusion Status
- 4.8 Reference No. 1339: Medical Control Guideline: Vascular Access

5. BUSINESS

Old:

- 5.1 Community Paramedicine (*July 18, 2012*)
- 5.2 EMSC Ad Hoc Committee (*May 20, 2015*)

New:

(None)

6. COMMISSIONERS COMMENTS/REQUESTS

7. LEGISLATION

8. EMS DIRECTOR'S REPORT

9. ADJOURNMENT

(To the meeting of September 21, 2016)

Lobbyist Registration: Any person or entity who seeks support or endorsement from the EMS Commission on official action must certify that they are familiar with the requirements of Ordinance No. 93-0031. Persons not in compliance with the requirements of the Ordinance shall be denied the right to address the Commission for such period of time as the noncompliance exists.

CONSENT CALENDAR

July 20, 2016

MINUTES

- May 18, 2016

2. CORRESPONDENCE

- 2.1 (6-30-2016) Larry Whithorn, Fire Chief, West Covina Fire Department: Newly Appointed Medical Director – Sean Henderson, M.D.
- 2.2 (6-28-2016) Distribution: Designation of Primary Stroke Centers
- 2.3 (6-27-2016) Aaron Aumann, NRP, EMS Department Supervisor, University of Antelope Valley: Paramedic Training Program Approval
- 2.4 (6-23-2016) ED Medical Directors and ED Nurse Managers, Each 9-1-1 Receiving Hospital: End-of-Life Option Act (Aid-In-Dying Drug)
- 2.5 (6-15-2016) Howard Backer, M.D., MPH, FACEP, Director, State Emergency Medical Services Authority: Extension of the Current Exclusive Operating Area Agreements for Emergency 9-1-1 Ambulance Transportation
- 2.6 (6-7-2016) Distribution: Suspended Emergency Department Approved for Pediatrics Status – Pacifica Hospital of the Valley
- 2.7 (6-1-2016) Eligible Physicians, Physicians Services for Indigents Program: Physician Services for Indigents Program – Trauma Services
- 2.8 (5-17-2016) Distribution: Comprehensive Stroke Center Implementation
- 2.9 (4-12-2016) The Honorable Board of Supervisors, County of Los Angeles: Approval of Amendments to Emergency Ambulance Transportation Services Agreements

3. COMMITTEE REPORTS

- 3.1 Base Hospital Advisory Committee
- 3.2 Data Advisory Committee
- 3.3 Education Advisory Committee
- 3.4 Provider Agency Advisory Committee

4. POLICIES – For your information

- 4.1 Reference No. 814: Determination/Pronouncement of Death in the Field
- 4.2 Reference No. 815: Honoring Prehospital Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment and End of Life Option (Aid-In-Dying-Drug)
- 4.3 Reference No. 815.3: Sample – Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner
- 4.4 Reference No. 815.4: End of Life Option Field Quick Reference Guide
- 4.5 Reference No. 1200: Treatment Protocols
- 4.6 Reference No. 1319: Medical Control Guideline: Medication Orders and Administration
- 4.7 Reference No. 1329: Medical Control Guideline: Perfusion Status
- 4.8 Reference No. 1339: Medical Control Guideline: Vascular Access



COUNTY OF LOS ANGELES EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670

(562) 347-1604 FAX (562) 941-5835

<http://ems.dhs.lacounty.gov/>

May 18, 2016

Los Angeles County Board of Supervisors

Hilda L. Solis

First District

Mark Ridley-Thomas

Second District

Sheila Kuehl

Third District

Don Knabe

Fourth District

Michael D. Antonovich

Fifth District

Commissioners

Mr. Robert Ower

LA County Ambulance Association

Chief Robert E. Barnes

Los Angeles County Police Chiefs Assn.

Mr. Frank Binch

Public Member (4th District)

Lt. Brian S. Bixler

Peace Officers Association of LA County

Erick H. Cheung, M.D., Vice Chair

Southern CA Psychiatric Society

Robert Flashman, M.D.

LA County Medical Association

Mr. John Hisserich

Public Member (3rd District)

Clayton Kazan, M.D., Chair

California Chapter-American College of

Emergency Physicians (CAL-ACEP)

Mr. James Lott

Public Member (2nd District)

Paul S. Rodriguez

CA State Firefighters' Association

Margaret Peterson, Ph.D.

Hospital Association of Southern CA

Nurses Sanossian, MD, FAHA

American Heart Association

Western States Affiliate

Carole A. Snyder, RN

Emergency Nurses Association

Chief David White

Los Angeles Area Fire Chiefs Association

Mr. Colin Tudor

League of Calif. Cities/LA County Division

Mr. Gary Washburn

Public Member (5th District)

VACANT

Public Member (1st District)

LA Surgical Society

Southern California Public Health Assn.

Executive Director

Cathy Chidester

(562) 347-1604

cchidester@dhs.lacounty.gov

Commission Liaison

Marilyn Rideaux

(323) 890-7392

mr Rideaux@dhs.lacounty.gov

COMMISSIONERS	ORGANIZATION	EMS AGENCY STAFF	POSITION
<input checked="" type="checkbox"/> Robert Ower	LAC Ambulance Assn	Cathy Chidester	Director, EMS Agency
* Robert Barnes	LAC Police Chiefs Assn	Kay Fruhwirth	Asst. Dir., EMS Agency
<input checked="" type="checkbox"/> Frank Binch	Public Member, 4 th District	Richard Tadeo	Asst. Dir, EMS Agency
<input checked="" type="checkbox"/> Erick H. Cheung, M.D.	So. CA Psychiatric Society	M. Gausche-Hill, MD	Medical Director, EMS
<input checked="" type="checkbox"/> Robert Flashman, M.D.	L.A. County Medical Assn	Marilyn Rideaux	Staff
<input checked="" type="checkbox"/> John Hisserich	Public Member, 3 rd District	Amelia Chavez	"
<input checked="" type="checkbox"/> James Lott	Public Member, 2 nd District	Christine Clare	"
<input checked="" type="checkbox"/> Clayton Kazan, M.D.	CAL/ACEP	Ernest Aldama	"
<input checked="" type="checkbox"/> Paul S. Rodriguez	CA State Firefighters' Assn.	April Ramelli	"
* Colin Tudor	League of California Cities		
* Margaret Peterson, PhD	HASC		
<input checked="" type="checkbox"/> Lt. Brian S. Bixler	Peace Officers Assn. of LAC		
* Nerses Sanossian, M.D.	American Heart Assn.		
<input checked="" type="checkbox"/> Carole Snyder	Emergency Nurses Assn.		
<input checked="" type="checkbox"/> Chief David White	LA Chapter-Fire Chiefs Association		
<input checked="" type="checkbox"/> Gary Washburn	Public Member, 5 th District		

GUESTS

Michael Murrey	Manhattan Beach FD	Jamie Garcia	HASC
David Baumann	LACoFD	Laurie Mejja	APCC
Victoria Hernandez	LACoFD	Nicole Steeneken	LACoFD
Steve Sanko	LAFD		

(Ab) = Absent; (*) = Excused Absence

CALL TO ORDER:

The Emergency Medical Services Commission (EMSC) meeting was held in the EMS Commission Hearing Room, 10100 Pioneer Blvd, Santa Fe Springs, 90670. The meeting was called to order at 1:10 PM by Chairman, Clayton Kazan. A quorum was present with 12 Commissioners in attendance.

ANNOUNCEMENTS/PRESENTATIONS:

Chairman Kazan announced that it was EMS Week. He thanked EMS providers for their service to Los Angeles County. Commissioner Bernard Weintraub received a Lifetime Achievement Award from the American Public Health Association. Commissioner Carole Snyder is a new member of the State EMS Commission.

Consent Calendar:

M/S/C: Commissioner Hisserich/Snyder to approve the Consent Calendar.

5. OLD BUSINESS

5.1 Community Paramedicine (July 18, 2012)

Currently there are two pilot projects active in Los Angeles County transportation of patients to alternate sites (ALTRANS) and Congestive Heart Failure (CHF). A site review was conducted by OSHPD last month. Since the start date of the study in September 2015, the CHF project is doing well. Both programs are progressing, however, enrollment in the ALTRANS program is low. There seems to be difficulty in getting patients to sign the consent to participate in the program and this is what we contribute to the low enrollment.

The CHF project is being supported by Glendale Fire Department. They have assigned a designated paramedic to work directly with Glendale Adventist Hospital and identify CHF discharges that would be benefit from a home visit to review medications and disease management. To date 120 patients have been enrolled in this pilot project and there has been a noticeable lower 30-day re-admission rate since the project started last year.

5.2 EMSC Ad Hoc Committee Report (May 20, 2015)

The EMSC Ad Hoc Committee on Behavioral Emergencies met on May 20. There was a very robust discussion on the current processes and trying to understand how law enforcement versus EMS is dispatched to these type calls and once on scene how patient destination is determined. The Committee outlined the system as it currently exists and started exploring what changes could be implemented in the way Mental Health patients are handled in the field in an attempt to streamline the system and provide the best destination and care of the patient.

One more follow-up meeting is anticipated to outline short-term, intermediate and long term goals. The Committee anticipates forwarding recommendations to the EMSC in July. If an additional meeting should become necessary, a report will be provided in September.

NEW BUSINESS

5.3 Los Angeles City Pilot Projects (Marc Eckstein, M.D.)

Dr. Marc Eckstein presented the Los Angeles City Fire's pilot projects:

- Fast Response Vehicle (FRV) utilizes a two member dual-response resource in an effort to decrease response times to critical patients, decrease the volume of fire suppression resources responding to EMS calls, and improve triage. FRVs carry all the equipment and medical supplies of a paramedic Mobile Intensive Care Unit and is also equipped with a 300 gallon water tank with pumping capacity. LAFD's goal is to decrease response times and improve operational efficiency by becoming more efficient and effective through the use of FRVs.

- Nurse Practitioner Response Unit (NPRU) is an innovative program that aims to address the needs of those who most frequently utilize Emergency Medical Services by providing direct, efficient on-scene care. Staffed with one firefighter-paramedic and a nurse practitioner, NPRUs will respond to medical emergencies which make up the majority of the fire department's calls. This pioneering approach is intended to free up firefighters to respond to other emergencies, provide comprehensive evaluation to the patient in the field, and link patient to close medical follow-up through community resources if not a life-threatening emergency.

6. Commissioners Comments/Requests

Commissioner Flashman – asked what was being done about the EMTALA violation stated in Correspondence 2.2. EMS personnel have been directed to report violations to base station. Also, there is a shortage of physicians in the County who can perform the necessary procedure on patients who experience bowel obstruction.

7. Legislation

Cathy Chidester highlighted Legislation currently on watch by EMSAAC: AB 510 (Rodriguez D) Wireless 911 calls: emergency telephone user surcharge; AB 1300 (Ridley-Thomas D) Mental health: involuntary commitment; AB 1748 (Mayes R) Pupils: pupil health: opioid antagonist; SB 867 (Roth D) Emergency medical services; SB 1300 (Hernandez D) Medi-Cal: emergency medical transport providers: quality assurance fee.

8. Director's Report

- The EMS Agency continues to work on implementation of Comprehensive Stroke Centers (CSC). The concept of CSC was first introduced in the EMS Update. Paramedics and MICNs will receive training on identifying patients who would most likely benefit from availability of a CSC. The patient must present with specific symptoms to receive rapid treatment at a CSC. Implementation of the program is anticipated in early 2017 pending approval of the program by the County Board of Supervisors.
- Los Angeles County approved an increase in the minimum wage. By the year 2020, minimum wage will be \$15.00 an hour. The EMS Agency was asked to do a report to the Board of Supervisors on the impact of the minimum wage on private ambulance companies. Based on this report, the County Ordinance Chapter 7 sections related to maximum allowable charges were amended and the basis for rate changes will be attached to the minimum wage increase. A request to approve the ordinance changes will go to the Board on May 24 and we anticipate to have the new rates in place by July 1 this year, pending Board approval.
- The RFP for Emergency Ambulance Transportation Services was released on February 4, 2016. The initial date for bid submission was May 4, 2016 but the bid submission date has been revised to June 23. The reason for the postponement was to allow ambulance companies to review the new rates based on the ordinance revision. The 2016 RFP is available for viewing on the EMS Agency's website.
- PSIP enrollment packages are going out in the mail in early June to about 6,000 physicians who are currently enrolled in the program. The current enrollment will end on June 30, 2016. This new enrollment period covers July 1, 2016 through June 30, 2019.
- The annual Sidewalk CPR Day is June 2. Last year 10,000 people were trained in Los Angeles County. Applications for participation are still being accepted and fire departments are strongly being encouraged to participate in the event. The EMS

- Agency will provide training at two DHS locations. A press conference to kick off the event will be held on June 2. A list of participants and training sites was distributed.
- EMS has been monitoring diversion and wall time at Gardena Memorial since approving a pilot project to open up a portion of the service area. They have requested to continue on the pilot through the end of May to make sure the process is going to work in the long run. EMS will be doing follow up.
 - A RFI (Request for Information) was sent out to hospitals in the SPA 6 area to obtain their interest in becoming a Level I Trauma Center. Hospitals that provide services to SPA 6 include St. Francis, California Hospital, Centinela, and Gardena. The deadline for the hospitals to submit the requested documents is May 26.
 - EMS is working on a policy for first responder training for police officers, lifeguards, and EMS personnel who are non-EMTs. A task force will be formed in the future to draft a policy.

9. Adjournment

The Meeting was adjourned by Chairman Clayton Kazan at 2:27 PM. The next meeting will be held on July 20, 2016.

Next Meeting: Wednesday, July 20, 2016
EMS Agency
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

Recorded by:
Marilyn Rideaux
EMS Agency Staff



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate and quality
emergency and disaster
medical services.*

Health Services
<http://ems.dhs.lacounty.gov>



June 30, 2016

Larry Whithorn, Fire Chief
West Covina Fire Department
1444 W. Garvey Avenue
West Covina, California 91790

Dear Chief Whithorn:

NEWLY APPOINTED MEDICAL DIRECTOR – Sean Henderson, MD

This letter is to acknowledge that the Emergency Medical Services (EMS) Agency has received the required documentation from West Covina Fire Department (WC) indicating that Sean Henderson, M.D., has been appointed as WC's Medical Director effective June 13, 2016.

The EMS Agency has also received the necessary documentation confirming Dr. Henderson will provide oversight for WC's Standing Field Treatment Protocol (SFTP) program, controlled substances, non-narcotic pharmaceuticals and medical supplies.

On June 13, 2016, all controlled drugs that were assigned to WC by LAC+USC Medical Center Pharmacy have been transferred to Dr. Henderson's medical license utilizing DEA Form-222. Since WC will not procure their controlled substances through the County pharmacy, the Controlled Substance Agreement (H-705833) between the City of West Covina and County of Los Angeles will be terminated. The termination of this Agreement will be addressed in a separate correspondence.

I would like to thank Dr. Henderson for his commitment to the Los Angeles County EMS system. If there are any questions during this transition or in the future, please don't hesitate to contact me directly.

Sincerely,


Marianne Gausche-Hill, MD
Medical Director

MGH:gw
6-15

- c. Medical Director, West Covina Fire Department
EMS Director, West Covina Fire Department
Paramedic Coordinator, West Covina Fire Department
Nurse Educator, West Covina Fire Department



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services*

June 28, 2016

TO: Distribution

VIA FAX/EMAIL

FROM: Marianne Gausche-Hill, MD
Medical Director

SUBJECT: DESIGNATION OF PRIMARY STROKE CENTERS

The Emergency Medical Services Agency is pleased to announce that effective Tuesday, July 5, 2016 the following 44 facilities are now designated as Primary Stroke Centers (PSC):

NEWLY APPROVED:

Providence Saint John's Health Center

PREVIOUSLY APPROVED:

- Antelope Valley Medical Center
- California Hospital Medical Center
- Cedars Sinai Medical Center
- Citrus Valley Medical Center – Queen of the Valley Campus
- Encino Hospital Medical Center
- Garfield Medical Center
- Glendale Adventist Medical Center
- Glendale Memorial Hospital and Health Center
- Good Samaritan Hospital
- Henry Mayo Newhall Hospital
- Hollywood Presbyterian Medical Center
- Huntington Hospital
- Kaiser Foundation Hospital – Baldwin Park Medical Center
- Kaiser Foundation Hospital – Downey Medical Center
- Kaiser Foundation Hospital – Los Angeles Medical Center
- Kaiser Foundation Hospital – Panorama City
- Kaiser Foundation Hospital – West Los Angeles
- Kaiser Foundation Hospital – Woodland Hills
- Lakewood Regional Medical Center
- Long Beach Memorial Medical Center
- Los Alamitos Medical Center (Orange County)
- Los Robles Hospital & Medical Center (Ventura County)
- Methodist Hospital of Southern California
- Mission Community Hospital
- Northridge Hospital Medical Center



Health Services
<http://ems.dhs.lacounty.gov>



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

June 27, 2016

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

Aaron Aumann, NRP
EMS Department Supervisor
University of Antelope Valley
44055 Sierra Highway
Lancaster, CA 93534

Dear Mr. Aumann:

PARAMEDIC TRAINING PROGRAM APPROVAL

Following review of your paramedic program and the site visit conducted on June 22, 2016, I am pleased to inform you the Los Angeles County Emergency Medical Services (EMS) Agency approves University of Antelope Valley (UAV) as a Los Angeles County Paramedic Training Program. This program approval is effective July 1, 2016 through June 30, 2020, beginning with UAV Paramedic Class No. 20. The class in progress, UAV Paramedic Class No. 19, remains under Kern County EMS Agency approval. As discussed with Lucy Hickey and Erika Reich at the site visit, it is understood that UAV will:

1. Relocate existing Paramedic classrooms and equipment from the Rosamond campus to the main UAV campus on Sierra Highway in Lancaster and no longer conduct paramedic didactic and skills training in Kern County.
2. Submit the proposed field internship schedule to the EMS Agency at least 60 days prior to beginning field internship for paramedic classes beginning after July 1, 2016.
3. Comply with State Paramedic training program regulations and Los Angeles County policies and procedures to include Reference No. 906, Paramedic Training Program Approval and Reference No. 903, Paramedic Intern Clinical Experience and Field Internship Requirements.

We would like to acknowledge UAV's recent acquisitions which utilize advances in technology to improve your student's learning environment. Your purchase of a patient care simulator dedicated to EMS training and software to facilitate the National Registry of EMT's portfolio requirements for paramedic students are two examples identified by EMS Agency staff at the site visit.

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate and quality
emergency and disaster
medical services.*

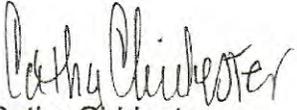
Health Services
<http://ems.dhs.lacounty.gov>



University of Antelope Valley
June 27, 2016
Page 2 of 2

For any questions, please contact Erika Reich, EMS Program Approvals at ereich@dhs.lacounty.gov or (562) 347-1638.

Sincerely,


Cathy Chidester
Director

CC:lh

c: Medical Director, EMS Agency
Director, Kern County EMS Agency
State of California, EMS Authority



**EMERGENCY MEDICAL
SERVICES AGENCY**
33 ANNE STREET

June 23, 2016

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

TO: ED Medical Directors, Each 9-1-1 Receiving Hospital
ED Nurse Managers, Each 9-1-1 Receiving Hospital

FROM: Marianne Gausche-Hill, MD, FACEP, FAAP
Medical Director, LA County EMS Agency

SUBJECT: END-OF-LIFE OPTION ACT (AID-IN-DYING DRUG)

As many of you are aware, in late 2015, the California Legislature passed the End-of-Life Option Act (AB 15), which became law on June 9, 2016. This Act allows for terminally ill patients in California who are mentally competent adults to voluntarily request and receive a prescription for medication to end the patient's life at a time of their choosing. This allows for a patient to have some control over the end of their life and gives patients dignity and comfort at the time of their death.

The law outlines many safeguards for the patient and includes language that the patient may rescind his/her wish to take the "aid-in-dying" drug at any time.

In order to prepare the EMS system to care for these patients with respect for their wishes, there have been modifications to a number of key Prehospital Care policies including Reference No. 814 – Determination of Death and Reference No. 815 – Honoring Do Not Resuscitate Orders, Physician Orders for Life Sustaining Treatment, and the End-of-Life Option (Aid-in-Dying drug). We have also included several attachments to Reference No. 815 pertaining to the End-of-Life Option. Reference No. 815.3 provides an example of an "attestation" that the patient intends to take the Aid-in- Dying Drug within 48 hours. An attestation may or may not be available at the time EMS arrives at a home of a patient who has taken the aid-in-dying drug. Reference No. 815.4 is an algorithm, which is intended to provide guidance on the management of these patients. Please distribute these documents to your ED staff.

EMS may be contacted when patients and their family members have concerns with the dying process or feel uncomfortable managing the patient during this process. If EMS is summoned to a patient who has exercised the end-of-life option under the Act, EMS personnel should determine who and why 9-1-1 was called and then obtain the written documentation regarding the patient's end-of-life decision, if at all possible. The EMS provider should withhold resuscitation if there are DNR orders or evidence that the person is one who is exercising their rights under the Act.

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

To ensure timely,
compassionate, and quality
emergency and disaster
medical services.

Health Services
<http://ems.dhs.lacounty.gov>



End-of-Life Option Act
June 23, 2016
Page 2

As part of the management algorithm, we have included the option for the EMS provider to contact the Base Physician for further guidance. Many families find it extremely difficult to watch their loved one die and the process may take minutes to days. We must recognize the impact of these events on a patient's family and loved ones and provide emotional support as necessary. Decisions on transporting a patient to the hospital will need to be made with consideration of documentation of the End-of-Life Option being implemented and a patient's POLST and/or AHCD. Families should be encouraged to remain home with the patient and the patient should be provided comfort care (airway positioning and suctioning).

We must also work collaboratively with EMS and hospital-based providers to make the best decisions on care and transport for the patient, and their families.

Please feel free to contact me if there are questions or concerns with this guidance
mgausche-hill@dhs.lacounty.gov

Reference:

California AB 15 – End of Life Act

https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB15

Attachments

- c. Director, EMS Agency
- Assistant Medical Director, EMS Agency
- Base Hospital Medical Directors
- EMS Provider Agency Medical Directors
- EMS Commission



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate and quality
emergency and disaster
medical services*



Health Services
<http://ems.dhs.lacounty.gov>

June 15, 2016

Howard Backer, MD
Director
State Emergency Medical Services Authority
10901 Gold Center Drive, Suite 400
Rancho Cordova, CA 95670

Dear Dr. Backer:

**EXTENSION OF THE CURRENT EXCLUSIVE OPERATING AREA
AGREEMENTS FOR EMERGENCY 9-1-1 AMBULANCE
TRANSPORTATION**

The Los Angeles County Emergency Medical Services (EMS) Agency is notifying the Emergency Medical Services Authority (EMSA) that the Los Angeles County Board of Supervisors (BOS) has approved a one-year extension to the current 7 Exclusive Operating Zone Agreements for Emergency Ambulance Transportation beyond the May 31, 2016 expiration date (attached).

BACKGROUND:

On March 16, 2006, following a RFP solicitation process, countywide Emergency Ambulance Transportation Exclusive Operating Area (EOA) Program agreements were effective for emergency ambulance transportation services covering a majority of the 88 incorporated cities and all unincorporated areas within Los Angeles County. The Emergency Ambulance Transportation EOA Program was implemented under Emergency Ambulance Transportation Services Agreements between the County and the current private providers for ten years. As authorized under the California Health and Safety Code section 1797.224, a local EMS agency may create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider or providers of the services pursuant to the plan.

In April 2013, the EMS Agency began developing an RFP for Emergency Ambulance Transportation Services 9-1-1 Response, and aimed to complete this process and the awarding of Emergency Ambulance Transportation Services Agreements for the EOAs prior to current agreements' expiration date of May 31, 2016. Due to the size and complexity of the EMS system in LA County, and the unique EMS functions within this jurisdiction, this original target date required a one year extension.

Following the EMSA Guideline #141, "Competitive Process for Creating Exclusive Operating Areas," an RFP was released on February 4, 2016 and the proposer's conference took place on February 24, 2016. Participants at the proposer's conference posed questions requiring

Howard Backer
June 15, 2016
Page 2

legal interpretation from our County Counsel, and these inquiries contributed to the need for an extension to the proposal due date.

Simultaneously, the EMS Agency was in the process of revising the County's Business License Ordinance pertaining to Maximum Allowable Charges outlined in the ambulance rate schedules. This effort was intended to help mitigate the effects of the County's new Minimum Wage Ordinance passed by the BOS in August 2015, on the ambulance industry operating in Los Angeles County.

Due to the proposed change to the Maximum Allowable Charges, the EMS Agency determined that ambulance companies responding to the RFP would need an extension to the due date for proposals to allow for them to calculate their rates based on the updated Maximum Allowable Charges approved by the BOS. The public hearing for the revised Maximum Allowable Charges took place on Tuesday, May 24, 2016; the motion for the proposed change required reading into the BOS minutes on Tuesday, May 31, 2016; and the revised Maximum Allowable Charges outlined in the ambulance rate schedule and methodology will be effective July 1, 2016, 30 days after the reading into the minutes (attached).

The revised due date for proposal submissions is June 23, 2016. The EMS Agency will then move forward with the review of the proposals, any possible appeals, and awards, as outlined in the RFP released this year.

The one year extension of current contracts between private ambulance companies and the County have been agreed upon by all contracting parties. This extension will ensure that there is no interruption/disruption of 911 emergency ambulance transport services during the completion of the RFP process. As you are aware, these contracts ensure compliance with the 1986 decision in *City of Lomita v. County of Los Angeles* 148 Cal. App. 3d 671, which obligated the County to provide emergency ambulance services to all "residents of the County". During this extension period, the County will continue uphold the terms of the existing contracts, which include exclusivity requirements within each operating area.

If you or your staff have any additional questions, feel free to call me at (562) 347-1604 or John Telmos, Chief Prehospital Operations at (562) 347-1677.

Sincerely,


Cathy Chidester
Director

CC:jt
06-07

Attachments

- c. Director, Department of Health Services
County Counsel
Contracts and Grants, Department Of Health Services
Tom McGinnis, Chief EMS Systems Division, EMSA



June 7, 2016

EMAIL

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate, and quality
emergency and disaster
medical services.*

TO: Distribution

FROM: Marianne Gausche-Hill, MD, FACEP, FAAP
Medical Director, LA County EMS Agency

**SUBJECT: SUSPENDED EMERGENCY DEPARTMENT APPROVED
FOR PEDIATRICS STATUS – PACIFICA HOSPITAL OF
THE VALLEY**

This is to advise you that the Emergency Medical Services Agency is suspending Pacifica Hospital of the Valley's (PAC) approval as an Emergency Department Approved for Pediatrics (EDAP) until further notice.

Effective Wednesday, **June 8, 2016 at 0700**, pediatric patients aged 14 years or younger shall no longer be transported via the 9-1-1 system to PAC. These patients shall be transported to surrounding EDAPs in the area in accordance with Ref. No. 510, Pediatric Patient Destination.

If you or your staff have any questions or require further information, please contact Karen Rodgers, RN, Pediatric and SART Programs Coordinator, at krodgers@dhs.lacounty.gov or (562) 347-1654.

CC:kr
06-02

- c. Director, EMS Agency
Medical Alert Center, EMS Agency
CEO, Pacifica Hospital of the Valley
Fire Chief, Los Angeles Fire Department
Medical Director, Los Angeles Fire Department
Fire Chief, Los Angeles County Fire Department
Medical Director, Los Angeles County Fire Department
CEO, American Medical Response
Paramedic Coordinator, American Medical Response
Prehospital Care Coordinator, Providence Holy Cross Medical Center
Prehospital Care Coordinator, Northridge Hospital Medical Center



Health Services
<http://ems.dhs.lacounty.gov>



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate and quality
emergency and disaster
medical services.*



Health Services
<http://ems.dhs.lacounty.gov>

June 1, 2016

TO: Eligible Physicians
Physician Services for Indigents Program

FROM: Cathy Chidester 
Director

SUBJECT: **PHYSICIAN SERVICES FOR INDIGENTS PROGRAM -
TRAUMA SERVICES**

The County of Los Angeles is opening enrollment in its Physician Services for Indigents Program (PSIP) for services provided to eligible trauma patients. This is a three-year enrollment period which covers County FYs 2016-17 through 2018-19 (July 1, 2016 through June 30, 2019).

Enrollment/Conditions of Participation

These reimbursement procedures and policies apply to services rendered to eligible patients **for a period of three (3) years from July 1, 2016 through June 30, 2019.**

Providers need to submit only one Conditions of Participation Agreement and one Program Enrollment Provider Form for all County Programs.

Each physician providing patient care under this program must complete an enrollment form and attach a copy of their current medical license. This form is for enrollment of a single physician, not a physician group. Any change in the physician information, e.g., office address change, will require resubmission of the enrollment form.

The Conditions of Participation Agreement serves as the official "contract" between the private physician and the County. Each physician participating in PSIP must personally sign and return the agreement. This agreement need only be submitted once during the enrollment period, along with the enrollment form.

Reimbursement Rate

The reimbursement rate for trauma services provided from July 1, 2016 to June 30, 2017 is still to be determined. Providers will be notified of the approved reimbursement rate once it is determined.

The following PSIP enrollment documents are attached to this letter:

1. PROGRAM ENROLLMENT PROVIDER FORM – JULY 1, 2016 TO JUNE 30, 2019
2. CONDITIONS OF PARTICIPATION AGREEMENT – JULY 1, 2016 TO JUNE 30, 2019
3. BILLING PROCEDURE
4. PHYSICIAN REIMBURSEMENT POLICIES
5. INSTRUCTIONS FOR CLAIMS SUBMISSION AND DATA COLLECTION
6. DEMOGRAPHIC DATA FORM

KEY INFORMATION POINTS IN THE ABOVE REFERENCED DOCUMENTS

- These reimbursement procedures and policies apply to services rendered to eligible patients for the period from July 1, 2016 through June 30, 2019.
- An eligible “trauma” patient is a patient at a designated trauma hospital with a TRAUMA PATIENT SUMMARY (TPS) number. Claims received without a TPS number will be reimbursed at the emergency services rate. Claims with inaccurate or invalid TPS numbers will be rejected until accurate information is submitted. We cannot reimburse physicians if the information in TEMIS indicates the patient has third-party coverage. These claims will be rejected and returned to the physician and may be resubmitted once TEMIS is revised to show the patient does not have third party coverage.
- Physicians providing services to eligible trauma patients may be reimbursed for services provided during the entire acute hospitalization.
- These procedures apply to all physicians providing care to eligible trauma patients, **INCLUDING EMERGENCY DEPARTMENT PHYSICIANS.**
- Each physician must complete a *Program Enrollment Provider Form* and *Conditions of Participation Agreement* before any claims will be processed. These documents may accompany the first claims submission.
- Enrollment forms and physician claims should be sent electronically or mailed directly to the County’s Contract Claims Adjudicator:

American Insurance Administrators (AIA)
P.O.Box 2340
Bassett, CA 91746-0340
(800) 303-5242

CC:kf

Attachments

c: Los Angeles County Medical Association
Hospital Association of Southern California



**EMERGENCY MEDICAL
SERVICES AGENCY**
OF LOS ANGELES COUNTY

May 17, 2016

VIA FAX/EMAIL

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

TO: Distribution

FROM: Marianne Gausche-Hill, MD, FACEP, FAAP
Medical Director, LA County EMS Agency

SUBJECT: **COMPREHENSIVE STROKE CENTER IMPLEMENTATION**

This is in response to the questions received by the EMS Agency regarding the implementation date of Comprehensive Stroke Centers (CSC) in the County of Los Angeles. As you may be aware the annual EMS Update training introduced the concept and rationale for implementing CSCs. The training also introduced the Los Angeles Motor Scale (LAMS) to be used by paramedics to identify patients most likely to benefit from interventions available at a CSC. The supporting policies for this change has an effective date of July 1, 2016, to begin the training of paramedics and MICNs in the utilization of LAMS.

The implementation date for the re-direction of stroke patients who have a LAMS score of 4 or greater from the closest primary stroke center to a CSC will occur on a later date (late 2016 or early 2017) once the EMS Agency designates CSCs.

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

The process for CSC designation will involve the development of the following:

- CSC Standards
- Data Collection and Submission Requirements
- Application and Designation Process

To ensure timely,
compassionate, and quality
emergency and disaster
medical services.

CSC certification from accrediting organizations, in of itself, is **not sufficient** to implement a regionalized comprehensive stroke system of care.

If you have any questions or need additional information, please do not hesitate to contact me or Dr. Nichole Bosson, Assistant Medical Director, at (562) 347-1600.

MGH:rt

- c. Director, EMS Agency
Assistant Medical Director, EMS Agency

Distribution:

CEO, Each Approved Stroke Center
Stroke Medical Director, Each Approved Stroke Center
Stroke Coordinator, Each Approved Stroke Center
Medical Director, Each EMS Provider Agency
Nurse Educator, Each EMS Provider Agency
Prehospital Care Coordinator, Each Base Hospital
Base Hospital Medical Director, Each Base Hospital



Health Services
<http://ems.dhs.lacounty.gov>



Health Services
LOS ANGELES COUNTY

23

April 12, 2016

Los Angeles County
Board of Supervisors

April 12, 2016

Hilda L. Soja
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

Mitchell H. Katz, M.D.
Director

Mal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Chief Operations Officer

**APPROVAL OF AMENDMENTS TO EMERGENCY AMBULANCE
TRANSPORTATION SERVICES AGREEMENTS
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)**

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

SUBJECT

Tel: (213)240-8101
Fax: (213)481-0503

Request approval of Amendments to extend the term of the Emergency Ambulance Transportation Services Agreements.

www.dhs.lacounty.gov

IT IS RECOMMENDED THAT THE BOARD:

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

1. Authorize the Director of Health Services (Director), or his designee, to execute Amendments to the Emergency Ambulance Transportation Services Agreements with the private providers listed in Attachment A, to extend the Agreement term for the period June 1, 2016 through December 31, 2016, for the continued provision of emergency ambulance transportation services, at no monetary cost to the County.

2. Delegate authority to the Director, or his designee, to execute future Amendments to the Emergency Ambulance Transportation Services Agreements to extend the term for up to an additional six months, for a potential term through June 30, 2017, with substantially similar terms and conditions, subject to prior review and approval by County Counsel and notification to the Board and the Chief Executive Office.



www.dhs.lacounty.gov

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Approval of these recommendations will allow the Director to execute Emergency Ambulance Transportation Services Agreement Amendments, substantially similar to Exhibit I, to extend the term of each Agreement for the period June 1, 2016 through December 31, 2016, with an option to further extend for up to six months through June 30, 2017, for the continued provision of emergency ambulance transportation services within Los Angeles County while the Department of Health Services (DHS) completes a Request for Proposals (RFP) solicitation process.

DHS and impacted County departments have coordinated with the California Emergency Medical Services Authority (EMSA) to develop a superseding Emergency Ambulance Transportation Services Agreement and the solicitation process to obtain such services. Implementation of the Affordable Care Act was taken into consideration in the RFP development. As required by the California Health and Safety Code (H&S) Division 2.5, Section 1797.224, the final RFP draft solicitation was submitted for review and approval to EMSA on September 9, 2015, and subsequently was approved by EMSA on January 21, 2016. DHS then released the approved RFP on February 4, 2016 with proposals originally due by May 4, 2016. The submission deadline was subsequently extended to May 12, 2016 to account for the additional time needed for the written questions to be answered. DHS plans to complete the solicitation process during the recommended extension period and seek Board approval of new Emergency Ambulance Transportation Services Agreements prior to the expiration date of the extended Agreements.

Implementation of Strategic Plan Goals

The recommended actions support Goal 3, Integrated Services Delivery, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

There is no monetary cost to the County under the Emergency Ambulance Transportation Services Agreements. The County provides certain in-kind services including support services and discounted dispatch services in exchange for the transport of County-Responsible patients. For the transport of all other patients, the providers bill the appropriate responsible party.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

As a means of satisfying a 1986 ruling by the California Court of Appeals which held the County responsible for the provision of emergency ambulance transportation services to all residents of the County, including persons within incorporated areas, the County's DHS created exclusive operating areas (EOAs) for contract providers, as authorized by H&S Code Division 2.5, Section 1797.224. Pursuant to this H&S Code, a local emergency medical services (EMS) agency may create one or more EOAs in the development of a local plan if a competitive process is utilized to select the provider or providers of the services pursuant to the plan. No competitive process is required if the local EMS agency develops or implements a local plan that continues the use of existing providers operating within a local EMS area in the manner and scope in which the services have been provided without interruption since January 1, 1981. A local EMS agency which elects to create one or more EOAs in the development of a local plan is required to develop and submit for approval to EMSA, as part of the local EMS plan, its competitive process for selecting providers and determining the scope of their operations.

On March 16, 2006, a Countywide Emergency Ambulance Transportation EOA Program was renewed for emergency ambulance transportation services covering a majority of the 88 incorporated cities within Los Angeles County and all of the County's unincorporated area, following an RFP solicitation process. The County's current Emergency Ambulance Transportation EOA Program includes seven (7) EOAs that cover all of the unincorporated County area and the territories of 59 incorporated cities. The Emergency Ambulance Transportation EOA Program was implemented under Emergency Ambulance Transportation Services Agreements between the County and the current private providers. The private providers exclusively receive 9-1-1 calls for emergency ambulance transportation services in their awarded EOA(s), except in major emergency or disaster situations. This exclusivity does not apply to any Federal, State, or County-operated ambulance vehicles, to a city-operated ambulance vehicle if authorized to transport by an authorized County agency, or to air ambulances if authorized to transport by an authorized County agency or by other lawful authority, all of which may be used within the private providers' EOA(s) to provide emergency ambulance transportation services.

For the remaining 29 incorporated cities in Los Angeles County, the County has contracted directly with the city governments for the provision of emergency ambulance transportation services by these cities within each city's respective jurisdiction. Since these cities have been providing services in the same manner and scope, and without interruption, since January 1, 1981, they are exempt from the competitive process requirement pursuant to H&S Code Section 1797.224.

The Agreements may be terminated for convenience by the County with 365 days' advance written notice.

County Counsel has approved Exhibit I as to form.

CONTRACTING PROCESS

Not applicable. These are extensions of existing agreements that were awarded as a result of an RFP.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will ensure that emergency ambulance transportation services will continue without interruption for the residents of Los Angeles County.

The Honorable Board of Supervisors
4/12/2016
Page 4

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Mitchell Katz". The signature is written in a cursive, flowing style.

Mitchell H. Katz, M.D.
Director

MHK:CC

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

Emergency Ambulance Transportation Services

Exclusive Operating Area	Private Provider
1	American Medical Response of Southern California
2	American Medical Response of Southern California
3	Schaefer Ambulance Service, Inc.
4	Westmed Ambulance, Inc. dba McCormick Ambulance
5	American Medical Response of Southern California
6	Care Ambulance Services, Inc.
7	Westmed Ambulance, Inc. dba McCormick Ambulance



**EMERGENCY MEDICAL SERVICES COMMISSION
BASE HOSPITAL ADVISORY COMMITTEE
MINUTES
June 8, 2016**



REPRESENTATIVES		EMS AGENCY STAFF
<input checked="" type="checkbox"/> Carole Snyder, RN, Chair	EMS Commission	Dr. Marianne Gausche-Hill
* <input checked="" type="checkbox"/> Margaret Peterson, Ph.D., Vice Chair	EMS Commission	Dr. Nichole Bosson
<input type="checkbox"/> Robert Flashman, M.D.	EMS Commission	Richard Tadeo
<input type="checkbox"/> Erick Cheung, Ph.D.	EMS Commission	Lucy Hickey
<input checked="" type="checkbox"/> Lila Mier	County Hospital Region	Paula Rashi
<input checked="" type="checkbox"/> Emerson Martell	County Hospital Region	John Telmos
<input type="checkbox"/> Jose Garcia	County Hospital Region, Alternate	Michelle Williams
<input type="checkbox"/> Yvonne Elizarraraz	County Hospital Region, Alternate	Dr. April Ramelli
<input checked="" type="checkbox"/> Jessica Strange	Northern Region	Greg Klein
<input checked="" type="checkbox"/> Karyn Robinson	Northern Region	GUESTS
<input type="checkbox"/> Mark Baltau	Northern Region, Alternate	Nichole Steeneken, LACoFD
<input type="checkbox"/> Kristina Crews	Southern Region	Victoria Hernandez, LACoFD
<input checked="" type="checkbox"/> Samantha Verga-Gates	Southern Region	Jennifer Marni
<input checked="" type="checkbox"/> Laurie Mejia	Southern Region	Michael Murrey, MB
<input checked="" type="checkbox"/> Lindy Galloway	Southern Region, Alternate	Lauren Spina, CSM
<input type="checkbox"/> Paula Rosenfield	Western Region	Annette Cornell, HCH
<input checked="" type="checkbox"/> Ryan Burgess	Western Region	Christine Farnham, LCM
<input type="checkbox"/> Alejandro Perez-Sandi	Western Region, Alternate	Tara Oswald, Physio
<input type="checkbox"/> Rosie Romero	Western Region, Alternate	Miguel Escobeda, LAFD
<input checked="" type="checkbox"/> Laurie Sepke	Eastern Region	Rick Moreno, LACoFD
<input type="checkbox"/> Alina Candal	Eastern Region	Nick Berkuta, LACoFD
<input checked="" type="checkbox"/> Jenny Van Slyke	Eastern Region, Alternate	Eleni Pappas, LACoFD
<input checked="" type="checkbox"/> Mike Hansen	Provider Agency Advisory Committee	Angel Lopez-Gomez, USC
<input type="checkbox"/> Isaac Yang	Provider Agency Advisory Committee, Alt.	
<input checked="" type="checkbox"/> Jazmin Gonzalez	MICN Representative	
<input type="checkbox"/> Jeff Warsler	MICN Representative, Alt.	
<input type="checkbox"/> Robin Goodman	Pediatric Advisory Committee	
<input checked="" type="checkbox"/> Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	
PREHOSPITAL CARE COORDINATORS		
<input checked="" type="checkbox"/> Jennifer Hunt (SMM)	<input checked="" type="checkbox"/> Adrienne Roel (AMH)	
<input checked="" type="checkbox"/> Heidi Ruff (NRH)	<input type="checkbox"/> Rachel Caffey (NRH)	
<input type="checkbox"/> Michael Steffen (AVH)	<input checked="" type="checkbox"/> Gloria Guerra (QVH)	
<input type="checkbox"/> Deanna Josing (HMN)	<input type="checkbox"/> Kelly Hauser, (QVH)	

1. **CALL TO ORDER:** The meeting was called to order at 1:04 P.M. by Carole Snyder, Chairperson.
2. **APPROVAL OF MINUTES** - The April 13, 2016 meeting minutes were approved as written.

M/S/C (Burgess/Verga) Approve the April 10, 2016 meeting minutes as written.

3. INTRODUCTIONS/ANNOUNCEMENTS

No announcements

4. REPORTS & UPDATES

4.1 Memorial Hospital of Gardena Service Area Pilot Project

Richard Tadeo reported that there continues to be no negative impact for the surrounding hospitals or providers with the removal of the west and south Service Area boundaries. Monitoring continues.

4.2 EMS Update 2016

The EMS Agency has issued a Q&A document to all participants of the Train-the-Trainer. The Q&A document contains all the questions received by the EMS Agency regarding EMS Update 2016. Please email Richard Tadeo for any additional comments or questions.

4.3 Comprehensive Stroke Center Implementation

The Committee was provided clarification on the implementation of Comprehensive Stroke Centers (CSC). Although three hospitals have received CSC certification from The Joint Commission or DNV, rerouting of patients from Primary Stroke Centers (PSC) to these accredited hospitals will not be implemented until the EMS Agency designates these hospitals as CSCs. Therefore, the policies that will become effective July 1, 2016 will impact the utilization of the Los Angeles Motor Scale (LAMS). EMS and base hospital personnel should start using and documenting the LAMS score starting July 1, 2016. This will allow the capture of data that will provide a more precise number of patients expected to be rerouted from PSCs to CSCs.

The EMS Agency is in the process of developing CSC standards and data collection requirements which will be vetted through a stakeholder's workgroup. CSC designation will include a written agreement with the EMS Agency.

4.4 STEMI Interpretation for EMS Providers

Committee was informed that the Paramedic Training Institute will be hosting a training on ECG interpretation of STEMI, June 28, 2016. The EMS Agency is requesting educators to attend and provide feedback regarding the training. Twelve openings remain available.

5. UNFINISHED BUSINESS

5.1 Electronic Base Form Documentation

Ryan Burgess reported that the development and testing of a real-time electronic base hospital form continues. It appears that the Surface Pro is preferred over a tough book. The next meeting is June 16, 2016.

5.2 Base Form Changes- 12-Lead ECG Interpretation

The EMS Agency has reviewed the process that was followed during the last revision of the Base Hospital Form and identified that a discussion on the mandatory fields did not occur. For future meetings regarding changes to the Base Hospital Form, the EMS Agency will ensure that mandatory data collection requirements will be discussed before final approval of the Base Hospital Form Instruction Manual.

With regard to the 12-Lead ECG interpretation, the EMS Agency finds that data collection of both the software and EMS interpretation are equally important, otherwise analysis of this data component will have very limited use. Therefore, this item will be a mandatory data collection requirement. EMS providers are

required to report these information to the base hospitals. The EMS Report Form was also revised to capture these items.

6. NEW BUSINESS

6.1 Los Angeles County Fire (CF) ePCR Implementation

Richard Tadeo discussed concerns surrounding CFs new ePCR. Paramedics are reporting an accurate booklet number but the transmission to the eXchanger adds an extra number. This will not affect base data entry but is concerning with other programs, such a STEMI, entering incorrect numbers from ePCR. Another issue includes CF's contact of the hospital's IT department versus the ED/PCCs.

Ryan Burgess identified four (4) core issues:

- Issue with the booklet numbers
- Paramedics wanting to complete the record back at their station
- Transfer of care/information to BLS or air providers
- Late notification of the base hospitals by CF/Physio-control

Battalion Chief (BC) Pappas identified areas CF is currently addressing:

- Training
- Overcoming cultural attitude
- Reviewing data to identify software issues
 - ❖ Software issue to fix booklet numbers
 - ❖ Fixing past booklet numbers
 - ❖ Fixing time issues
 - ❖ Mapping to EMS

BC Pappas communicated that many of the issues identified already have corrections in progress.

Committee members expressed the need for improved communication as the process continues and the need for "go-live" dates to be disseminated to the PCCs for the remaining areas of the CF rollouts.

6.2 Reference No. 814, Determination/Pronouncement of Death in the Field

The Committee was provided back ground on the rationale for the addition of "head" in Policy I. A. 7 (page 3 of 7). There is literature to support that a subset of patients who sustain penetrating torso injury will benefit from emergent thoracotomy. A concern was voiced regarding prolonged scene and transport times. Committee agreed to forward to Medical Council for further discussion. A recommendation was made to add scene/transport time parameters (e.g. 10-15 minutes) to distinguish between those patients that may receive emergency thoracotomy.

Policy VII. A., Add language "any provider acting in good faith is immune to liability"

**M/S/C (Burgess/Van Slyke) Approve Reference No. 814,
Determination/Pronouncement of Death in the Field with recommended
changes**

6.3/6.4 Reference No. 815, Honoring DNR Orders, Physician Orders for Life Sustaining Treatment and End of Life Options (Aid-in-Dying Drug) through Ref. 815.4, End of Life Option Quick Reference Guide

The Committee was provided an overview of the End-of-Life Option Act which become effective June 9, 2016.

Reference No. 815, Policy III, Add language “any provider acting in good faith is immune to liability”

Ref. No. 815.4: Committee recommended under “Is a Final Attestation available?”- Yes, Provide supportive measures. Do not start resuscitation if patient is in cardiopulmonary arrest-add “Consult with base Medical Director”.

Committee members requested a letter be sent to the base physicians regarding education on this new law.

M/S/C (Burgess/Galloway) Approve Reference No. 815 – 815.4, honoring end of life decisions and the end of life quick reference guide with recommended changes.

6.5 Reference No. 1200, Treatment Protocols

No changes.

M/S/C (Galloway/Van Slyke)

6.6 Reference No. 1304, Medical Control Guideline: Airway/Oxygenation/Ventilation-Tabled

6.7 Reference No. 1308, Medical Control Guideline: Cardiac Monitoring/ECG-Tabled

6.8 Reference No. 1319, Medical Control Guideline: Medication Orders and Administration

Add to Guidelines 1.a. iv, into a large muscle group.

M/S/C (Burgess/Van Slyke) with recommended changes.

6.9 Reference No. 1329, Medical Control Guideline: Perfusion Status

No changes.

M/S/C (Van Slyke/Verga-Gates)

6.10 Reference No. 1339, Medical Control Guideline: Vascular Access

No changes.

M/S/C (Van Slyke/Verga-Gates)

BHAC
June 8, 2016

7. OPEN DISCUSSION

New Co-PCCs

Providence Little Company of Mary – Torrance, Christine Farnham-Natalie Burciago

8. NEXT MEETING: August 10, 2016

9. ADJOURNMENT: The meeting was adjourned at 3:00 P.M.



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**Los Angeles County
Board of Supervisors**

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

**EMERGENCY MEDICAL SERVICES COMMISSION
DATA ADVISORY COMMITTEE**

MEETING NOTICE

Date & Time: Wednesday, June 8, 2016 10:00 A.M.
Location: EMS Agency, First Floor Hearing Room
10100 Pioneer Boulevard
Santa Fe Springs, 90670-3736

**DATA ADVISORY COMMITTEE
DARK FOR JUNE 2016**

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562) 941-5835

*To ensure timely,
compassionate and quality
emergency and disaster
medical services.*



Health Services
<http://ems.dhs.lacounty.gov>



**COUNTY OF LOS ANGELES EMERGENCY MEDICAL
SERVICES COMMISSION 10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
(562) 347-1500 FAX (562) 941-5835**



EDUCATION ADVISORY COMMITTEE

(Report not available at time of mailing)



EMERGENCY MEDICAL SERVICES COMMISSION

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES

Wednesday, June 15, 2016

MEMBERSHIP / ATTENDANCE

MEMBERS

- Dave White, Chair
- Robert Ower, Vice-Chair
- LAC Ambulance Association
- LAC Police Chiefs' Association
- Jodi Nevandro
 - Sean Stokes
- Nick Berkuta
 - Kevin Klar
 - Clayton Kazan, MD
 - Victoria Hernandez
- Ken Leasure
 - Susan Hayward
- Richard Roman
 - Mike Beeghly
- Josh Hogan
 - Joanne Dolan
- Mike Hansen
 - Michael Murrey
- Corey Rose
 - Miguel Escobedo
- Brandon Greene
 - VACANT
- Jenny Van Slyke
 - Alina Chandal
- VACANT
 - James Michael
- Maurice Guillen
 - Scott Buck
- Marc Eckstein, MD
 - Stephen Shea, MD
- Diane Baker
 - Vacant

ORGANIZATION

- EMSC, Commissioner
- EMSC, Commissioner
- EMSC, Commissioner
- EMSC, Commissioner
- Area A
- Area A Alt (Rep to Med Council, Alt)
- Area B
- Area B, Alt.
- Area B, Alt.
- Area B Alt. (Rep to Med Council)
- Area C
- Area C, Alt
- Area E
- Area E, Alt.
- Area F
- Area F, Alt.
- Area G (Rep to BHAC)
- Area G, Alt. (Rep to BHAC, Alt.)
- Area H (Rep to DAC)
- Area H, Alt.
- Employed EMT-P Coordinator (LACAA)
- Employed EMT-P Coordinator, Alt. (LACAA)
- Prehospital Care Coordinator (BHAC)
- Prehospital Care Coordinator, Alt. (BHAC)
- Public Sector Paramedic (LAAFCA)
- Public Sector Paramedic, Alt. (LAAFCA)
- Private Sector EMT-P (LACAA)
- Private Sector EMT-P, Alt. (LACAA)
- Provider Agency Medical Director (Med Council)
- Provider Agency Medical Director, Alt. (Med Council)
- Private Sector Nurse Staffed Ambulance Program (LACAA)
- Private Sector Nurse Staffed Ambulance Program, Alt (LACAA)

EMS AGENCY STAFF PRESENT

- | | |
|--------------------|-------------------|
| Nichole Bosson, MD | Richard Tadeo |
| Chris Clare | Cathlyn Jennings |
| Christy Preston | John Telmos |
| David Wells | Michelle Williams |
| Greg Klein | |

OTHER ATTENDEES

- | | |
|------------------|----------------|
| Ivan Orloff | Downey FD |
| Ian Wilson | PRN Ambulance |
| Monica Bradley | Culver City FD |
| Roger Braum | Culver City FD |
| Trevor Stonum | MedCoast Amb |
| Tisha Hamilton | Bowers Amb |
| Scott Martinez | El Segundo FD |
| Nicole Steeneken | LACoFD |

LACAA – Los Angeles County Ambulance Association * LAAFCA – Los Angeles Area Fire Chiefs Association * BHAC – Base Hospital Advisory Committee * DAC – Data Advisory Committee

CALL TO ORDER: Chair, Commissioner Dave White called meeting to order at 1:00 p.m.

1. APPROVAL OF MINUTES: (Leasure/Berkuta) April 20, 2016 minutes were approved as written.

2. INTRODUCTIONS / ANNOUNCEMENTS

2.1 BHAC Representative for PAAC

- Jenny Van Slyke, Huntington Memorial Hospital, will be replacing Lindy Galloway as Committee's Representative from Base Hospital Advisory Committee.

3. REPORTS & UPDATES

3.1 Memorial Hospital of Gardena Service Area Pilot Project (Richard Tadeo)

- Gardena's service area project had no significant impact on hospitals in the area. Anticipating this pilot will move forward to a permanent status. Announcements will be provided as changes develop.

3.2 EMS Update 2016 (Richard Tadeo)

- Deadline to complete EMS Update 2016 is June 30, 2016
- Letters to PCC's and paramedic coordinators were sent out by the EMS Agency's License/Certification Section, requesting training rosters in order to reconcile the EMS Agency's training records.

3.3 Comprehensive Stroke Center Implementation (Richard Tadeo)

- Implementation of Comprehensive Stroke Centers will be postponed and will not go into effective on July 1, 2016 as previously planned. However, all providers are to begin documenting the Los Angeles Motor ScoreScale (LAMS) score effective July 1, 2016.

3.4 General Public Ambulance Rates – July 1, 2016 through June 30, 2017 (John Telmos)

- Annual adjustments to the General Public Ambulance Rates go into effect July 1, 2016. Announcement letter with the adjusted rates were available during this Committee meeting and is posted on the EMS Agency webpage.

3.5 Standardized Drug Formulary (Richard Tadeo)

- To assist with the prevention of medication errors, Los Angeles County will be implementing the use of standardized formulation for all pediatric medications effective September 1, 2016.
- Standardizing the concentration of medications carried on the ALS units will allow drug orders to be given in the exact milliliters (rather than milligram doses).
- Training modules will be available.
- Providers are encourage to begin purchasing the approved drug formulary as soon as possible. Drug formulary handout was available during this Committee meeting.

4. UNFINISHED BUSINESS: There were no unfinished business.

5. NEW BUSINESS

5.1 Reference No. 814, Determination / Pronouncement of Death in the Field (Richard Tadeo)

Policies reviewed and approved as presented.

M/S/C (Berkuta/Leasure): Approve Reference No. 814, Determination / Pronouncement of Death in the Field.

5.2 Reference No. 815, Honoring Prehospital Do No Resuscitate Orders, Physician Order for Life Sustaining Treatment and End of Life Options (Aid-In-Dying Drug) (Richard Tadeo)

Policies reviewed and approved as presented.

M/S/C (Hansen/Greene): Approve Reference No. 815, Honoring Prehospital Do No Resuscitate Orders, Physician Order for Life Sustaining Treatment and End of Life Options (Aid-In-Dying Drug).

5.3 Reference No. 815.3, Sample – Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner (Richard Tadeo)

Policies reviewed and approved as presented.

M/S/C (Hansen/Greene): Approve Reference No. 815.3, Sample – Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner.

5.4 Reference No. 815.4, End of Life Option **Field** Quick Reference Guide(Richard Tadeo)

Policy reviewed and approved with the following recommendation:

- EMS Agency provide a letter to base hospital physicians on education direction for this policy.

M/S/C (Hansen/Greene): Approve Reference No. 815.4, End of Life Option **Field Quick Reference Guide.**

5.5 Reference No. 1200, Treatment Protocol: General Instructions for Treatment Protocols (Richard Tadeo)

Policies reviewed and approved as presented.

M/S/C (Berkuta/Baker): Approve Reference No. 1200, Treatment Protocol: General Instructions for Treatment Protocols.

5.6 Reference No. 1304, Medical Control Guideline: Airway Oxygenation / Ventilation (Richard Tadeo)

Policy tabled until further review by EMS Agency.

Tabled Reference No. 1304, Medical Control Guideline: Airway Oxygenation / Ventilation.

5.7 Reference No. 1308, Medical Control Guideline: Cardiac Monitoring / ECG (Richard Tadeo)

Policy reviewed and approved as presented.

M/S/C (Leasure/Escobedo): Approve Reference No. 1308, Medical Control Guideline: Cardiac Monitoring / ECG.

5.8 Reference No. 1319, Medical Control Guideline: Medication Orders and Administration (Richard Tadeo)

Policy reviewed and approved as presented.

M/S/C (Greene/Baker): Approve Reference No. 1319, Medical Control Guideline: Medication Orders and Administration.

5.9 Reference No. 1329, Medical Control Guideline: Perfusion Status (Richard Tadeo)

Policy reviewed and approved as presented.

M/S/C (Hogan/Hansen): Approve Reference No. 1329, Medical Control Guideline: Perfusion Status.

5.10 Reference No. 1339, Medical Control Guideline: Vascular Access (Richard Tadeo)

Policy reviewed and approved as presented.

M/S/C (Berkuta/Greene): Approve Reference No. 1339, Medical Control Guideline: Vascular Access.

6. OPEN DISCUSSION: No topics for open discussion.

7. NEXT MEETING: August 17, 2016

8. ADJOURNMENT: Meeting adjourned at 2:00 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DETERMINATION/PRONOUNCEMENT
OF DEATH IN THE FIELD** (EMT/ PARAMEDIC/MICN)
REFERENCE NO. 814

PURPOSE: This policy is intended to provide EMS personnel with parameters to determine whether or not to withhold resuscitative efforts in accordance with the patient's wishes, and to provide guidelines for base hospital physicians to discontinue resuscitative efforts and pronounce death.

AUTHORITY: California Health and Safety Code, Division 2.5
California Probate Code, Division 4.7
California Family Code, Section 297-297.5
California Health and Safety Code, Division 1, Part 1.8, Section 443 et seq.

DEFINITIONS:

Advance Health Care Directive (AHCD): A written document that allows patients who are unable to speak for themselves to provide health care instructions and/or appoint a Power-of-Attorney for Health Care. There is no one standard format for an AHCD. Examples of AHCDs include:

- Durable power of attorney for Healthcare (DPAHC)
- Healthcare proxies
- Living wills (valid in California if dated prior to 7-1-2000; advisory but not legally binding after that date)

Agent: An individual, eighteen years of age or older, designated in a durable power of attorney for health care to make health care decisions for the patient, also known as "attorney-in-fact".

Aid-in-Dying Drug: A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to terminal illness. The prescribed drug may take effect within minutes to several days after self-administration.

Conservator: Court-appointed authority to make health care decisions for a patient.

Determination of Death: To conclude that a patient has died by conducting an assessment to confirm the absence of respiratory, cardiac, and neurologic function.

End of Life Option Act: This California state law authorizes an adult, eighteen years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his or her life in a humane and dignified manner.

Immediate Family: The spouse, domestic partner, adult children, or adult sibling(s) of the patient.

EFFECTIVE: 10-10-80
REVISED: 06-21-16
SUPERSEDES: 09-01-15

PAGE 1 OF 7

APPROVED: 
Director, EMS Agency


Medical Director, EMS Agency

Organized ECG Activity: A narrow complex supraventricular rhythm.

Pronouncement of Death: A formal declaration by a base hospital physician that life has ceased.

Standardized Patient-Designated Directives: Forms or medallions that recognize and accommodate a patient's wish to limit prehospital treatment at home, in long term care facilities, or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No. 815.2)
- State EMS Authority-approved DNR Medallion

PRINCIPLES:

1. Resuscitative efforts are of no benefit to patients whose physical condition precludes any possibility of successful resuscitation.
2. EMTs and paramedics may **determine** death based on specific criteria set forth in this policy.
3. Base hospital physicians may **pronounce** death based on information provided by the paramedics in the field and guidelines set forth in this policy.
4. If there is any objection or disagreement by family members or EMS personnel regarding terminating or withholding resuscitation, basic life support (BLS) resuscitation, including defibrillation, may continue or begin immediately and paramedics should contact the base hospital for further directions.
5. Aggressive resuscitation in the field to obtain the return of spontaneous circulation (ROSC) is encouraged. Transporting patients without ROSC is discouraged.
6. EMS personnel should honor valid do-not-resuscitate (DNR) orders and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

POLICY:

- I. EMS personnel may determine death in the following circumstances:
 - A. In addition to the absence of respiration, cardiac activity, and neurologic reflexes, one or more of the following physical or circumstantial conditions exist:
 1. Decapitation
 2. Massive crush injury

-
3. Penetrating or blunt injury with evisceration of the heart, lung or brain
 4. Decomposition
 5. Incineration
 6. Pulseless, non-breathing victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication.
 7. Penetrating trauma patients who, based on the paramedic's thorough assessment, are found apneic, pulseless, asystolic, and without pupillary reflexes upon the arrival of EMS personnel at the scene.
 8. Blunt trauma patients who, based on a paramedic's thorough patient assessment, are found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) due to traumatic mechanism upon the arrival of EMS personnel at the scene.
 9. Pulseless, non-breathing victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures.
 10. Drowning victims, when it is reasonably determined that submersion has been greater than one hour.
 11. Rigor mortis (requires assessment as described in Section I, B.)
 12. Post-mortem lividity (requires assessment as described in Section I, B.)
- B. If the initial assessment reveals rigor mortis and/or post-mortem lividity only, EMTs and/or paramedics shall perform the following assessments (may be performed concurrently) to confirm the absence of respiratory, cardiac, and neurologic function for determination of death in the field:
1. Assessment of respiratory status:
 - a. Assure that the patient has an open airway.
 - b. Look, listen and feel for respirations. Auscultate the lungs for a minimum of 30 seconds to confirm apnea.
 2. Assessment of cardiac status:
 - a. Auscultate the apical pulse for a minimum of 60 seconds to confirm the absence of heart sounds.
 - b. Adults and children: Palpate the carotid pulse for a minimum of 60 seconds to confirm the absence of a pulse.
 - c. Infants: Palpate the brachial pulse for a minimum of 60 seconds to confirm the absence of a pulse.

3. Assessment of neurological reflexes:
 - a. Check for pupillary response with a penlight or flashlight to determine if pupils are fixed and dilated.
 - b. Check and confirm unresponsive to pain stimuli.
 - C. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I. A. require immediate BLS measures to be initiated. If one or more of the following conditions is met, resuscitation may be discontinued and the patient is determined to be dead:
 1. A valid standardized patient-designated directive indicating DNR.
 2. A valid AHCD with written DNR instructions or the agent identified in the AHCD requesting no resuscitation.
 3. Immediate family member present at scene:
 - a. With a patient-designated directive on scene requesting no resuscitation
 - b. Without said documents at scene with full agreement of others, if present, requesting no resuscitation
 4. Parent or legal guardian is required and must be present at scene to withhold or terminate resuscitation for patients less than 18 years of age.
 - II. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I require immediate cardiopulmonary resuscitation in accordance with Ref. No. 1210, Treatment Protocol: Non-Traumatic Cardiac Arrest (Adult). Base contact for medical direction shall be established when indicated by Ref. No. 1210.
 - A. EMS Personnel may determine death if a patient is in **asystole** after 20 minutes of quality cardiopulmonary resuscitation on scene and meets ALL of the following criteria:
 1. Patient 18 years or greater
 2. Arrest not witnessed by EMS personnel
 3. No shockable rhythm identified at any time during the resuscitation
 4. No ROSC at any time during the resuscitation
 5. No hypothermia
 - B. Base Physician consultation for pronouncement is not required if Section A is met.
-

-
- C. Base Physician contact shall be established for all patients in cardiopulmonary arrest who do not meet the conditions described in Section I or IIA of this policy.
- III. Physician guidelines for transport versus termination
- A. Resuscitation should be continued on-scene until one of the following:
1. ROSC is confirmed with a corresponding rise in EtCO₂
 2. Base physician determines further resuscitative efforts are futile
 3. Decision to transport after 20 minutes of quality resuscitation on-scene and ROSC is not achieved
- B. Patients who have not achieved ROSC after 20 minutes of quality on-scene resuscitation **should** be considered for transport if:
1. Arrest witnessed by EMS personnel
 2. Persistent VF/VT rhythm after three (3) shocks delivered
- C. Additional considerations for transport of pulseless non-breathing patients **may** include:
1. Suspected reversible non-cardiac etiologies, including hypothermia
 2. Paramedic judgment (i.e., unsafe environment, public location)
 3. Shock delivered at any time during the resuscitation
- IV. Crime Scene Responsibility, Including Presumed Accidental Deaths and Suspected Suicides
- A. Responsibility for medical management rests with the most medically qualified person on scene.
- B. Authority for crime scene management shall be vested in law enforcement. To access the patient it may be necessary to ask law enforcement officers for assistance to create a "safe path" that minimizes scene contamination.
- C. If law enforcement is not on scene, EMS personnel should attempt to create a "safe path" and secure the scene until law enforcement arrives.
- V. Procedures Following Pronouncement of Death
- A. The deceased should not be moved without the coroner's authorization. Any invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient should be left in place.

NOTE: If it is necessary to move the deceased because the scene is unsafe, the body is creating a hazard, or the body is at risk of loss

through fire or flood, the EMS personnel may relocate the deceased to a safer location or transport to the most accessible receiving facility.

- B. If law enforcement or the coroner confirms that the deceased will not be a coroner's case and the personal physician is going to sign the death certificate, any invasive equipment used during the resuscitation may be removed.
- C. EMS personnel should remain on scene until law enforcement arrives. During this time, when appropriate, the provider should provide grief support to family members.

VI. Required Documentation for Patients Determined Dead/Pronounced in the Field

- A. The time and criteria utilized to determine death; the condition, location and position of the body, and any care provided.
- B. The location and the rationale if the deceased was moved. If the coroner authorized movement of the deceased, document the coroner's case number (if available) and the coroner's representative who authorized the movement.
- C. Time of pronouncement and name of the pronouncing physician if base hospital contact was initiated
- D. The name of the agent identified in the AHCD or patient-designated directive or the name of the immediate family member who made the decision to withhold or withdraw resuscitative measures. Obtain their signature on the EMS Report Form.
- E. If the deceased is **not** a coroner's case and their personal physician is going to sign the death certificate:
 - 1. Document the name of the coroner's representative who authorized release of the patient, and
 - 2. The name of the patient's personal physician signing the death certificate, and
 - 3. Any invasive equipment removed

VII. End of Life Option Act

- A. Resuscitation shall be withheld on patients in cardiopulmonary arrest who have self-administered an aid-in-dying drug (see Ref. No. 815.4, End of Life Option Field Quick Reference Guide).
- B. Document the presence of a Final Attestation and attach a copy if available.

CROSS REFERENCE:

Prehospital Care Manual:

- Reference No. 518, **Decompression Emergencies/Patient Destination**
- Reference No. 519, **Management of Multiple Casualty Incidents**
- Reference No. 606, **Documentation of Prehospital Care**
- Reference No. 806, **Procedures Prior to Base Contact**
- Reference No. 808, **Base Hospital Contact and Transport Criteria**
- Reference No. 815, **Honoring Prehospital Do Not Resuscitate Orders**
- Reference No. 815.1, **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**
- Reference No. 815.2, **Physician Orders for Life-Sustaining Treatment (POLST) Form**
- Reference No. 815.3, **Sample - Final Attestation For An Aid-In-Dying Drug to End My Life
in a Humane and Dignified Manner**
- Reference No. 815.4, **End of Life Option Field Quick Reference Guide**
- Reference No. 819, **Organ Donor Identification**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)
REFERENCE NO. 815

SUBJECT: **HONORING PREHOSPITAL DO NOT
RESUSCITATE ORDERS, PHYSICIAN ORDERS
FOR LIFE SUSTAINING TREATMENT AND
END OF LIFE OPTION (AID-IN-DYING DRUG)**

PURPOSE: To allow EMS personnel to honor valid Do Not Resuscitate (DNR) orders or Physician Orders for Life-Sustaining Treatment (POLST) and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

AUTHORITY: California Health and Safety Code, Division 1, Part 1.8, Section 442 – 443
California Health and Safety Code, Division 2.5, Section 1797.220 and 1798
California Probate Code, Division 4.7 (Health Care Decisions Law)

DEFINITIONS:

Advance Health Care Directive (AHCD): A written document that allows an individual to provide healthcare instructions and/or appoint an agent to make healthcare decisions when unable or prefer to have someone speak for them. AHCD is the legal format for healthcare proxy or durable power of attorney for healthcare and living will.

Aid-in-Dying Drug: A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to terminal illness. The prescribed drug may take effect within minutes to several days after self-administration.

Basic Life Support (BLS) measures: The provision of treatment designed to maintain adequate circulation and ventilation for a patient in cardiac arrest without the use of drugs or special equipment. Examples include:

- Assisted ventilation via a bag-mask device
- Manual or automated chest compressions
- Automated External Defibrillator (AED) – only if an EMT is on scene prior to the arrival of paramedics

Comfort measures: Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.

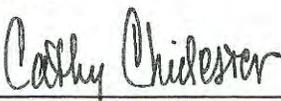
Do Not Resuscitate: DNR is a request to withhold interventions intended to restore cardiac activity and respirations. For example:

- no chest compressions
- no defibrillation
- no endotracheal intubation

EFFECTIVE: 06-01-92
REVISED: 06-21-16
SUPERSEDES: 02-28-15

PAGE 1 OF 7

APPROVED: _____


Director, EMS Agency


Medical Director, EMS Agency

- no assisted ventilation
- no vasoactive drugs

End of Life Option Act: This California state law authorizes an *adult*, eighteen years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an “aid-in-dying drug” prescribed for the purpose of ending his or her life in a humane and dignified manner.

Physician Orders for Life Sustaining Treatment (POLST): A signed, designated physician order form that addresses a patient’s wishes about a specific set of medical issues related to end-of-life care. May be used for both adult and pediatric patients.

Resuscitation: Interventions intended to restore cardiac activity and respirations, for example:

- cardiopulmonary resuscitation
- defibrillation
- drug therapy
- other life saving measures

Standardized Patient-Designated Directives: Forms or medallion that recognizes and accommodates a patient’s wish to limit prehospital treatment at home, in long term care facilities or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form, (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No.815.2)
- State EMS Authority-Approved DNR Medallion

Supportive Measures: Medical interventions used to provide and promote patient comfort, safety, and dignity. Supportive measures applicable for POLST and AHCD may include but are not limited to:

- Airway maneuvers, including removal of foreign body
- Suctioning
- Oxygen administration
- Hemorrhage control
- Oral hydration
- Glucose administration
- Pain control (i.e., morphine)

Valid DNR Order for Patients in a Licensed Health Care Facility:

- A written document in the medical record with the patient's name and the statement “Do Not Resuscitate”, “No Code”, or “No CPR” that is signed and dated by a physician, or
- A verbal order to withhold resuscitation given by the patient’s physician who is physically present at the scene and immediately confirms the DNR order in writing in the patient’s medical record, or
- POLST with DNR checked, or
- AHCD when the instructions state resuscitation should be withheld/discontinued

Valid DNR Order for Patients at a Location Other Than a Licensed Facility:

- EMSA/CMA Prehospital Do Not Resuscitate Form, fully executed, or
- DNR medallion, or
- POLST with DNR checked, or
- AHCD when the instructions state resuscitation should be withheld/discontinued

PRINCIPLES:

1. The right of patients to refuse unwanted medical intervention is supported by California statute.
2. Withhold or discontinue patient resuscitation if a valid AHCD or standardized patient-designated directive is provided.
3. If the patient's personal physician will sign the death certificate, invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient may be removed.
4. Patients are encouraged to utilize one of the standardized patient-designated directives to ensure that end-of-life wishes are easily recognizable. If the patient is in a private home, the DNR or POLST should be readily accessible or clearly posted.
5. Photocopies of all the patient-designated directives are acceptable.
6. After a good faith attempt to identify the patient, EMS personnel should presume that the identity is correct.
7. A competent person may revoke their patient-designated directive at any time.
8. An adult individual, eighteen years or older, who has the capacity to make medical decisions and has a terminal illness may receive a prescription for an aid-in-dying drug and self-administer the aid-in-dying drug in order to end his or her life in a humane and dignified manner.
9. A health care provider, including EMS personnel, shall not be subject to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with the End of Life Option Act.

POLICY:

- I. GENERAL PROCEDURES FOR EMS PERSONNEL FOR PATIENTS WITH A DNR, POLST OR AHCD
 - A. Confirm the patient is the person named in the patient-designated directive. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.
 - B. Initiate BLS measures immediately on patients in cardiopulmonary arrest pending
-

verification of a valid patient-designated directive or the criteria for discontinuing resuscitative measures outlined in Reference 814, Determination/ Pronouncement of Death in the Field, Policy I, C, have been met.

- C. Begin resuscitation immediately and contact the base hospital for further direction if family members/caretakers disagree or object to withholding resuscitation, or if EMS personnel have any reservations regarding the validity of the DNR directive.
- D. Transport to the facility designated by the physician or family members if the patient's condition deteriorates during transport and they have a valid DNR. This includes 9-1-1 and non-9-1-1 transports.
- E. Documentation of a DNR incident shall include, but is not limited to, the following:
 - 1. Check the "DNR" box on the EMS Report Form.
 - 2. Describe the care given. Print the base hospital physician's name, if consulted, and the date of the DNR directive.
 - 3. Note the removal of any invasive equipment.
 - 4. Document DNR orders written in the medical record of a licensed facility, including, the date signed, physician name, and other appropriate information or provide a copy of the DNR with the EMS Report Form.
 - 5. Provide a copy of the AHCD and/or other patient-designated directive with the EMS Report Form, when possible.

II. DIRECTIVE-SPECIFIC PROCEDURES

A. AHCD

- 1. A valid AHCD must be:
 - a. Completed by a competent person age 18 or older
 - b. Signed, dated, and include the patient's name
 - c. Signed by two witnesses or a notary public
 - d. Signed by a patient advocate or ombudsman if the patient is in a skilled nursing facility
- 2. If the situation allows, EMS personnel should make a good faith effort to review the AHCD and/or consult with the patient advocate.
- 3. Base contact is required for any AHCD instructions other than withholding resuscitation.
- 4. If the agent or attorney-in-fact is present, they should accompany the patient to the receiving facility.

B. State EMS Authority-Approved DNR Medallion

1. A medallion or bracelet attached to the patient is considered the most accurate form of identification for anyone not in a licensed facility.
2. Medallions are issued only after a copy of the DNR or POLST is received from an applicant. There are two (2) medallion providers approved in California; contact information:

a. Medic Alert Foundation
2323 Colorado Avenue
Turlock, CA 95382
Phone: 24-hour Toll Free Number (888) 633.4298
Toll Free FAX: (800) 863-3429
www.medicalert.org



b. Caring Advocates
2730 Argonauta St
Carlsbad, CA 92009
Phone: 1-800-647-3223
www.caringadvocates.org



3. If the medallion is engraved "DNR", treat in accordance with Ref. No. 815.1, Prehospital Do Not Resuscitate Form.
4. If the medallion is engraved "DNR/POLST" and the POLST is available, treat as indicated on the POLST.
5. If the medallion is engraved "DNR/POLST" and the POLST is **not available**, treat in accordance with the DNR until the valid POLST is produced.

C. Physician Orders for Life Sustaining Treatment (POLST)

1. The POLST must be signed and dated by the physician, and the patient or the legally recognized decision maker. No witness to the signatures is necessary.
2. The POLST is designed to supplement, not replace an existing AHCD. If the POLST conflicts with the patient's other health care instructions or advance directive, then the most recent order or instruction governs.
3. In general, EMS personnel should see the written POLST unless the patient's physician is present and issues a DNR order.
4. There are different levels of care in Sections A and B of the POLST. Medical interventions should be initiated, consistent with the provider's scope of practice and POLST instructions.

5. Contact the base hospital for direction in the event of any unusual circumstance.
- III. END OF LIFE OPTION ACT: A patient who has obtained an aid-in-dying drug has met extensive and stringent requirements as required by California law. The law offers protections and exemptions for healthcare providers but is not explicit about EMS response for End of Life Option Act patients. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered an aid-in-dying drug.
- A. Within 48 hours prior to self-administering the aid-in-dying drug, the patient is required to complete a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner". However, there is no mandate for the patient to maintain the final attestation in close proximity of the patient. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.
 - B. There are no standardized "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner" forms but the law has required specific information that must be in the final attestation (see sample Ref. No. 815.3). If available, EMS personnel should make a good faith effort to review and verify that the final attestation contains the following information:
 1. The document is identified as a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner"
 2. Patient's name, signature and dated
 - C. Provide comfort measures (airway positioning, suctioning) and/or airway/ventilation measures when applicable.
 - D. Withhold resuscitative measures if patient is in cardiopulmonary arrest. If a POLST or AHCD is present, follow the directive as appropriate for the clinical situation.
 - E. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental state. In this instance, EMS personnel shall provide medical care based on the discussion with the patient and as per standard protocols. EMS personnel are encouraged to consult with their base hospital in these situations.
 - F. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act, inform the family that comfort measures will be provided and consider Base Hospital contact for further direction.
 - G. Obtain a copy of the final attestation and attach it with the EMS Report Form,

SUBJECT: **HONORING PREHOSPITAL DO NOT
RESUSCITATE ORDERS, PHYSICIAN ORDERS
FOR LIFE SUSTAINING TREATMENT AND
END OF LIFE OPTION (AID-IN-DYING DRUG)**

REFERENCE NO. 815

when possible.

CROSS REFERENCE:

Prehospital Care Manual

Reference No. 502, **Patient Destination**

Reference No. 606, **Documentation of Prehospital Care**

Reference No. 808, **Base Hospital Contact and Transport Criteria**

Reference No. 814, **Determination/Pronouncement of Death in the Field**

Reference No. 815.1, **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**

Reference No. 815.2, **Physician Orders for Life-Sustaining Treatment (POLST) Form**

Reference No. 815.3, **Sample - Final Attestation For An Aid-In-Dying Drug to End My Life
in a Humane and Dignified Manner**

Reference No. 815.4, **End of Life Option Field Quick Reference Guide**

Emergency Medical Services Authority #111: Recommended Guidelines for EMS Personnel
Regarding Do Not Resuscitate (DNR) and Other Patient-Designated
Directives Limiting Prehospital Care, 4th Revision, October 2013

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/PARAMEDIC/MICN)
REFERENCE NO. 815.3

SUBJECT: **SAMPLE – FINAL ATTESTATION FOR AN
AID-IN-DYING DRUG TO END MY LIFE IN A
HUMANE AND DIGNIFIED MANNER**

**FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND
DIGNIFIED MANNER**

I, Patient Name, am an adult of sound mind and a resident of the State of California.

I am suffering from, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified matter. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed:

Dated:

Time:

EFFECTIVE: 06-21-16
REVISED:
SUPERSEDES:

APPROVED: _____
Director, EMS Agency Medical Director, EMS Agency

EMS responds to a patient with indications of taking Aid-In-Dying Drug (e.g., Presence of a Final Attestation, Aid-In-Dying Drug Vial/Container, verbal confirmation from family/significant other)

Yes

Determine reason for contacting 9-1-1 and address patient needs and requests as per standard protocols. Contact Base as needed.

Is patient conscious?

No

Is the patient alone?

Yes

Is a Final Attestation available?

No

Yes

No

No objection from family/significant other.

Determine reason for contacting 9-1-1 and provide **comfort** measures (airway position and suctioning). **Do not start resuscitation if patient is in cardiopulmonary arrest.**

Objection from family/significant other. Final Attestation is present.

Determine reason for contacting 9-1-1 and provide **comfort** measures (airway position and suctioning). **Do not start resuscitation if patient is in cardiopulmonary arrest. Consult with Base Physician for further direction.**

Objection from family/significant other. Final Attestation is **NOT** present.

Provide **airway/ventilation** measures. **Consult with Base Physician for further direction.**

GENERAL INSTRUCTIONS FOR TREATMENT PROTOCOLS

The Treatment Protocols were developed by combining the Base Hospital Treatment Guidelines (BHTG) and the Standing Field Treatment Protocols (SFTP). The foundations for the revised guidelines are the paramedic scope of practice, medical research, and community standards in medical practice. A sign/symptom orientation to treating the prehospital care patient has been retained.

GENERAL INFORMATION

1. Patients with the same disease may have differing complaints and presentations, and conversely, patients with similar signs and symptoms may have very different diagnoses.
2. The Treatment Protocols guide treatment of “classic” presentations based on evidence-based practice. Base hospital physicians, mobile intensive care nurses (MICNs) and paramedics must utilize their medical knowledge, expertise and critical thinking to determine appropriate treatments for each patient.
3. The protocols were not developed with the intent that all therapies be done on scene. Transport of patients with treatment en route is left to the discretion of the base hospital and the field unit.

PROTOCOL FORMAT

1. Pharmacologic agents are in **bold** typeface.
2. Pediatric treatments are preceded by the Los Angeles County Emergency Department Approved for Pediatrics (EDAP) teddy bear symbol. 
3. Paramedics must measure all pediatric patients using a length-based resuscitation tape (e.g., Broselow) and report the identified color code and weight in kilograms when contacting the base hospital. The color and weight in kilograms are documented on the EMS Report Form in the patient weight section. Medication dosages are then determined by correlating the length-based resuscitation tape color with the appropriate weight on the Color Code Drug Doses/L.A. County Kids chart or the pediatric doses in the Drug Administration section. If the child is longer than the length-based resuscitation tape, use adult dosing.
4. The **Special Considerations** section has additional helpful information specific to the chief complaint and/or specific patient population.

USING THE TREATMENT PROTOCOLS

Determine the patient’s chief complaint or problem and then identify the protocol that best meets their needs.

EFFECTIVE DATE: 7-1-11
REVISED: XX-XX-XX
SUPERSEDES: 04-15-15

PAGE 1 OF 3

APPROVED: _____

Director, EMS Agency

Medical Director, EMS Agency

1. The treatment protocol sequence is intended to guide the priority in which interventions are administered.
2. If more than one treatment protocol applies, begin by using the one most closely associated with the patient's primary complaint. Utilize Reference No. 806.1, Procedures Prior to Base Contact, as indicated and refer to other treatment protocols as needed.
3. If the patient's status changes, a different treatment protocol might be needed. Select the new treatment protocol by taking into account the treatments already performed.
4. Not all the treatment protocols have an SFTP component. Some have only procedures that can be done under Ref. No. 806.1 and then base contact is required. Report the treatment protocol number or name when making base contact such as, "we have a crush injury and are utilizing Ref. No. 1277" or "we are using the crush injury treatment protocol".
5. All treatment protocols will be located in Section 1200 of the Prehospital Care Manual; therefore, each protocol should be documented in the designated sections of the Base Hospital Report Form or EMS Report Form.
6. The SFTP portion of the treatment protocols can only be used by approved SFTP provider agencies.

CONTACT THE BASE HOSPITAL WHEN:

1. Patient meets Ref. No. 808, Base Hospital Contact and Transport Criteria, Section I
2. ALS intervention is performed and the provider agency is not an authorized SFTP provider
3. Additional or unlisted treatments are required
4. Consultation with the base hospital would be helpful
5. ST Elevation Myocardial Infarction (STEMI) notification and destination are required
6. Stroke notification, last known well date and time, and destination are required

STANDING FIELD TREATMENT PROTOCOL (SFTP) PROVIDERS

Additional treatments that can be performed by an approved SFTP provider prior to base contact are identified by "**Continue SFTP or Base Contact**". All subsequent treatments may be performed until the paramedic reaches the notation "**Establish Base Contact**". Once "**Establish Base Contact All**" appears, all ensuing treatments require an order from the base hospital.

The following dysrhythmias require establishing base hospital contact:

- Symptomatic Bradycardia
- Supraventricular Tachycardia (SVT)
- Ventricular Tachycardia (contact not required if utilizing Cardiac Arrest protocol and no pulse is present)
- Ventricular Fibrillation
- Second and Third Degree Heart Blocks
- Symptomatic Atrial Fibrillation/Atrial Flutter

If base hospital contact is made to obtain patient care orders, a full patient report will be given. If the patient meets trauma guidelines but is being transported to a non-trauma hospital, a full patient report must be given. Once base hospital contact is made for medical control, all subsequent treatments listed in the protocol require base hospital order.

It is the expectation when providing receiving hospital report for patient notification only, the following minimal patient information will be provided:

All Patients

Provider Code/Unit #

Sequence Number

Location (if 9-1-1 transfer)

Chief complaint

Age and units

Gender

Level of distress

Name of the protocol (number optional)

Glasgow Coma Scale (GCS), if altered

Airway adjuncts utilized, if applicable

Destination/ETA

Additional information if:

Trauma Complaint and transporting to a trauma center

Mechanism of injury

Location of injuries/pertinent information (flail segment, rigid abdomen, evisceration, etc.)

Complete vital signs and GCS

Pediatric

Pediatric Weight (in kg from weight-based tape) and Color Code (if applicable)

STEMI

12-Lead ECG rhythm/interpretation if the 12-lead ECG indicates STEMI, to include quality of tracing

mLAPSS (modified Los Angeles Prehospital Stroke Screen) performed:

If positive/met

Last known well date and time

Blood glucose

LAMS (Los Angeles Motor Scale) score, if applicable

MEDICAL CONTROL GUIDELINE: MEDICATION ORDERS AND ADMINISTRATION

PRINCIPLES:

1. A complete and accurate medication order is essential for patient care.
2. Closed-loop communication (repeating orders back to the base hospital) reduces medication errors.

GUIDELINES:

1. Base Hospitals must provide complete medication orders to include:
 - a. Name of the medication
 - b. Dose (adults in mg and in pediatric patients mg and mL to be delivered)
 - c. Route of administration
 - i. Inhalation (IH)
 - ii. Intravenous (IV)
 - iii. Intravenous Piggy-Back (IVPB)
 - iv. Intramuscular (IM) – in a large muscle group; lateral thigh for pediatrics
 - v. Intranasal (IN)
 - vi. Intraosseous (IO)
 - vii. Orally Disintegrating Tablet (ODT)
 - viii. Per Os (PO)
 - ix. Sublingual (SL)
 - d. Frequency of administration, if applicable
2. Paramedics are to repeat complete orders back to the base hospital.
3. PRN orders should have indications for administration.

MEDICAL CONTROL GUIDELINE: PERFUSION STATUS

PRINCIPLES:

1. Perfusion status is determined by a combination of parameters that includes heart rate, blood pressure, tissue color and mentation. No one parameter alone can be used to determine perfusion status.
2. Adequate perfusion is defined as adequate circulation of blood through organs and tissues, manifested by normal pulse, tissue color, level of consciousness and blood pressure.
3. Poor perfusion is defined as inadequate circulation of blood through organs and tissues manifested by vital sign abnormalities and/or signs and symptoms of organ dysfunction.
4. Base hospital contact should be initiated on patients who are hypotensive and/or those who have poor perfusion.

GUIDELINES:

1. EMS providers should evaluate for the following signs and use clinical judgement to determine poor perfusion status, which may include but not limited to:
 - a. Adult systolic blood pressure (SBP) less than 90mmHg, pediatric SBP less than 70mmHg
 - b. Bradycardia, tachycardia and/or poor pulse quality (weak/thready)
 - c. Altered mental status (including anxiety, restlessness, lethargy, combative behavior)
 - d. Delayed capillary refill time (greater than 2 seconds) and/or changes in tissue color including pallor, cyanosis or mottling

MEDICAL CONTROL GUIDELINE: VASCULAR ACCESS

PRINCIPLES:

1. Vascular access is a catheter inserted intravenously (IV) or a needle intraosseously (IO) through which medication and/or fluid bolus can be administered.

GUIDELINES:

1. Saline lock: IV device used intermittently for patients with stable vital signs or patients who may need limited IV medications or fluid volume.
2. Normal Saline fluid challenge/bolus/resuscitate:
 - a. Medical Adult: 10mL/kg rapid IV fluid administration with reassessment at 250mL increments; if presence of rales, stop infusion; otherwise continue up to 10mL/kg.
 - b. Trauma Adult: 250mL increments
 - c. Pediatric: 20mL/kg See Color Code Drug Doses/L.A. County Kids, reassess after initial fluid challenge
3. Intraosseous Access – refer to Ref. No. 1318, Medical Control Guideline: Intraosseous Access
4. Pre-Existing Vascular Access Devices – refer to Ref. No. 1330, Medical Control Guideline: Pre-Existing Vascular Access Devices